NEBRASKA ADMIMSTRATIVE CODE

Title 210 -- NEBRASKA DEPARTMENT OF INSURANCE

Chapter 44 -- SCOPE OF COVERAGE TO BE OFFERED BY THE NEBRASKA COMPREHENSIVE HEALTH INSURANCE POOL

001. Authority. This rule is issued pursuant to the authority granted by Neb.Rev.Stat. §44-101.01 and 44-4226.

002. Purpose. The purpose of this rule is to set forth the scope of the coverage to be offered by the Comprehensive Health Insurance Pool.

003. Definitions. For the purpose of this rule, unless the context otherwise requires, the definitions found in Neb.Rev.Stat. §44-4204 through 44-4215 shall apply.

004. Deductible. Each individual applying for coverage under the pool shall select one of the following deductible levels, which must be satisfied in each calendar year before any benefits will be payable:

004.01 For standard major medical plan:

004.01(a) $250 per year

004.01(b) $500 per year

004.01(c) $1,000 per year

004.01(d) $1,500 per year

004.01(~~d~~e) $2,000 per year

004.01 (f) $3,000 per year

004.01 (g) $4,000 per year

004.01 (h) $5,000 per year

004.02 For Preferred Provider Organization Plan:

004.02(a) $250/$500 per year;

004.02(b) $500/$1,000 per year;

004.02(c) $1,000/$2,000 per year;

004.02(d) $1,500 / $3,000 per year

004.02(~~d~~e) $2,000/$4,000 per year.

004.02(f) $3,000 / $6,000 per year

004.02(g) $4,000 / $8,000 per year

004.02(h) $5,000 / $10,000 per year

005. Cost containment.

005.01 The policy offered by the Comprehensive Health Insurance Pool may include one or more cost containment features which affect the level of benefits which will be paid. For purposes of this rule, "Cost Containment" is defined as formal activity related to the control of health services costs through efforts such as improved efficiency, utilization review, or claims review. It includes the following:

005.01A Hospital Confinement Preauthorization;

005.01B Outpatient Surgery;

005.01C Hospital Preadmission Testing;

005.01D Generic Drug Purchase, and

005.01E Preferred provider insurance arrangement.

006. Exceptions and limitations.

006.01 No benefits will be payable for:

006.01A Expense incurred while the policy is not in force.

006.01B Charges made by a physician for the treatment or movement of the teeth or tissues next to the teeth, except due to injury.

006.01C Injuries or sickness for which any benefits are provided for by workers' compensation or employer's liability laws whether or not you assert rights to such coverage.

006.01D Care of treatment in a hospital owned or operated by the United States Government or any of its agencies unless you are obligated to pay such charges.

006.01E Eye refractions, eyeglasses, contact lenses, hearing aids or their fitting.

006.01F Refractive corneal surgery, except for corneal grafts.

006.01G Private duty nursing.

006.01H Loss that results from an act of declared or undeclared war.

006.01I Loss sustained while in an armed service (Upon notice to the Pool of entry into a service, the pro rata premium will be refunded).

006.01J Normal childbirth, normal pregnancy, (unless insured purchases the optional Maternity Benefit Rider); or voluntarily induced abortion, or care of a newborn infant, except as provided by 00 8.01K.

006.01K Complications of pregnancy when the pregnancy had its inception before the policy date.

006.01L Gender transformations or changes or the promotion of fertility including (but not limited to):

006.O1L(l) Fertility tests.

006.O1L(2) Reversal of surgical sterilization; and

006.01L(3) Direct attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization or embryo transfer.

006.01M Routine physical exams or tests, except as provided in 008.01I and 008.01J.

~~006.01N Self-inflicted injuries or sickness.~~

006.01~~O~~N Expenses incurred for the transplant of a part of the insured person's body to the body of another.

006.01~~P~~O Treatment of a pre-existing condition until the policy has been in force at least six months.

006.01~~Q~~P Expenses incurred for services or treatment not medically necessary, or not administered or not provided under supervision of a physician.

006.01~~R~~Q Investigative or experimental services and supplies.

006.01~~S~~R Any expenses incurred that are covered by any local, state or federal programs;

006.01~~T~~S Loss that is covered by any other insurance plan.

006.01~~U~~T Services or supplies for any person other than the insured.

006.01~~V~~U Services performed by a member of the insured's immediate family.

006.01~~W~~V Education or training of any type, including biofeedback, treatment of learning disabilities and attention deficit disorders, IQ testing unless expressly provided for in the policy.

006.01~~X~~W Weight modification or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, or breast reduction or augmentation.

006.01~~Y~~X Transplant surgery which is not precertified; and

006.01~~Z~~Y Custodial care.

007. Covered services and supplies.

007.01 The following services will be considered covered services and supplies for which a benefit will be payable.

007.01A Hospital room and board and any other hospital furnished medical services and supplies. Limitations and conditions may be imposed where confinement is in a private room or intensive-care facility.

007.01B Services of a physician.

007.01C Services of a physical or speech therapist acting under the direction of a physician.

007.01D Anesthetics and their administration.

007.01E X-ray and laboratory examinations.

007.01F Skilled nursing facility benefits, subject to the following conditions and limitations;

007.01F(l) Benefits payable for up to 30 days in a calendar year;

007.01F(2) Confinement must begin within 14 days of discharge from hospital confinement which lasts at least three days in a row;

007.01F(3) Care is for the same condition which caused the hospital confinement; and

007.01F(4) Care is given in a skilled nursing facility which is a place licensed to provide skilled care to resident persons. It must have a registered graduate nurse (RN) on call 24 hours a day.

007.01G Ambulance services for:

007.01G(1) Local professional land and air ambulance service; and

007.01G(2) Transportation within the United States by a professional nonair ambulance or on a regularly scheduled flight on a commercial airline when:

007.O1G(2)(a) Special and unique Covered Hospital Services are required which are not provided by a local hospital;

007.O1G(2)(b) Transportation is medically necessary; and

007.O1G(2)(c) Transportation is to the nearest hospital equipped to furnish the services;

007.01H The following medical supplies:

007.01H(1) blood and blood plasma;

007.01H(2) artificial eyes or prosthetic limbs;

007.01H(3) surgical dressings, casts, splints, trusses, braces, (except dental braces) crutches, or heart pacemakers;

007.01H(4) oxygen and the rental or purchase of equipment for its administration;

007.01H(5) rental or purchase of a wheelchair or hospital type bed or other medically necessary durable medical equipment;

007.01H(6) rental or purchase of mechanical equipment required for respiratory paralysis; and

007.O1H(7) drugs and medicines that require a prescription are purchased upon a physicians' orders and dispensed by a licensed pharmacist.

007.01H(8) Where applicable the option of rental or purchase shall be determined by the pool.

007.01I The following services for a Hospice Care Program:

007.01I(1)(a) Room and board in a hospice while you are an inpatient;

007.01I(1)(b) Respite Care: Short-term Inpatient care which is necessary for you in order to give temporary relief to the person who regularly assists with the care at home. Respite Care must be provided in a Skilled or Intermediate Care Nursing facility that is affiliated with the Hospice that is providing services to you. Respite Care in a Skilled or Intermediate Care Nursing facility need not meet our normal Medical Necessary criteria ordinarily applied to Inpatient admissions;

007.01I(1)(c) The rental of medical appliances and equipment while the terminally ill covered person is in a hospice care program to the extent that such items would have been covered under the policy if the covered person had been confined in a hospital;

007.O1I(1)(d) Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;

007.01I(2) Such services must be provided by a hospital related institution, home health agency, hospice or other licensed facility which would be approved under Medicare or any applicable state law as a Hospice Care Program

007.01I(3) "Hospice Care Program" means a program for meeting the special needs of terminally ill individuals and their immediate families, by providing support and care during the illness and bereavement:

007.01I(3)(a) A "Terminally ill" individual is defined as an individual who has no reasonable prospect of cure and, as estimated by a physician, has a life expectancy of less than six months.

007,01I(4) Notwithstanding the provisions of any other sections of this rule, benefits for the above hospice care are limited as follows:

007.01I(4)(a) Benefits are payable only if the terminally ill person is the insured person.

007.01I(4)(b) Benefits for counseling (other than bereavement counseling) for the insured person's immediate family are not to exceed a total maximum benefit of $500. (The immediate family includes the insured person's spouse, children, and parents); and

007.01I(4)(c) Benefits for bereavement counseling for the insured person's immediate family are not to exceed a total maximum benefit of $100.

007.01I(5) In addition to the Exclusions and Limitations found in Section 006, benefits for Hospice Care will not be provided for:

007.01I(5)(a) Services performed by volunteers;

007.01I(5)(b) Pastoral services, or legal or financial counseling services;

007.01I(5)(c) Services which are primarily for the convenience of the patient, or a person other than the patient;

007.01I(5)(d) Home delivered meals;

007.01I(5)(e) Any maintenance therapy which is not designed to improve the insured's condition; or

007.01I(5)(f) Services for Mental illness.

007.01J Home Health Care received in lieu of hospitalization, furnished under a planned program by an agency licensed to provide home health care, and ordered or directed by a physician;

007.01K Diabetes Patient Education Program.

007.01L Cosmetic or Reconstructive Surgery, but only if required due to injuries received while the policy is in force or for conditions resulting from surgery for which benefits are paid under the policy.

007.01M Radiation therapy or treatment.

007.01N Ambulatory Surgical Facility expenses.

007.010 Services of a mental health practitioner.

007.01P Cardiac or pulmonary rehabilitation program

008. Benefits.

008.01A Except as indicated elsewhere in this rule, when an insured person incurs an expense for a covered service or supply, the pool will cover 80% of the usual, normal charges in excess of the deductible. The Preferred Provider Organization Plan may reduce the coverage of the charges to 70% if an insured person does not obtain a covered service or supply from a contracted medical provider with the pool. Benefits are limited to; (a) one million dollars~~$500,000~~ during the lifetime of the insured; and (b) expense incurred after the deductible has been satisfied.

008.01B The following are exceptions to the general benefit payable under subsection 008.01:

008.01B(1) Hospital confinement preauthorization is required and when expenses are incurred for days of hospital confinement which are not preauthorized in accordance with the requirement of the policy:

008.01B(2) Benefits for these expenses will not exceed 75% of the expense incurred in excess of the deductible for all covered expenses;

008.01B(3) Those expenses will not be used to satisfy the maximum out-of-pocket expense amount described in section 009;

008.01B(4) The 75% limitation will be applied regardless of whether the individual has previously satisfied the maximum out-of-pocket expense amount.

008.01C Expenses for hospital preadmission testing will be paid at 100% of the usual customary and reasonable charges subject to the following limitations:

008.01C(1) The insured person must be admitted to the hospital as an inpatient within seven days after the pre-admission testing for the same condition for which the test was performed. If not, benefits will be considered at 80% of covered services after the deductible.

008.01C(2) If the tests are duplicated on an inpatient basis, benefits for the original and duplicate test will be considered at 80% of covered services after the deductible.

008.01D Where home health care expenses have been incurred and such care is received in lieu of hospitalization, furnished under a planned program by an agency licensed to provide home health care, and ordered and directed by your physician, the pool will pay benefits in excess of the deductible as follows:

008.01D(1) 100% of the expense incurred for the first 10 days of home health care in a calendar year.

008.01D(2) 80% of the expense incurred for the next 30 days of home health care in a calendar year.

008.01D(3) Expense incurred after the 40th day of home health care in a calendar year will not be payable, nor will they be used in satisfying the Maximum Out-of-Pocket Expense Amount or deductible.

008.01E Expenses incurred by the insured person who enrolls, participates and completes a Diabetes Patient Education Program will be paid at 90%. The deductible will not apply, but the following limitations are applicable:

008.01E(1) The maximum amount payable is $500 during the insureds lifetime.

008.01E(2) The person taking the program must be the insured.

008.01E(3) The person that has diabetes must be the insured person.

008.01E(4) Charges in excess of the $500 maximum will not be used to satisfy the deductible or maximum out-of-pocket expense amount.

008.01E(5) What constitutes Diabetes Patient Education Program will be defined in the policy.

008.01F For the standard medical plan t~~T~~he pool will pay 100% of the expense incurred after the deductible has been met for generic drugs that require a prescription, are based upon a physicians orders, and are dispensed by a licensed pharmacist. A physician must approve of the insured person taking the generic drug. For the PPO plan there is a copay imposed that ranges from $10 to $15 for generic drugs and from $20 to $50 for brand name drugs depending upon the deductible plan.

008.01F(l) For purposes of this provision, "Generic Drug" means a drug:

008.01F(l)(a) that meets all Federal Drug Administration standards;

008.01F(l)(b) that does not have a registered trademark; and

008.01F(1)(c) whose name can be used by more than one drug company.

008.01G Where an insured receives an organ transplant, from a Preferred Transplant Center, the benefits payable for covered services and supplies will be the maximum provided as stated in the insurance contract. Where an insured receives an organ transplant from a non-approved provider, the maximum benefits payable for covered services and supplies will be limited to $100,000. No benefits are payable unless prior certification has been granted by the medical review board determining an organ transplant to be medically necessary.

008.01H Benefits for Mental Diseases or Disorders, Alcoholism or Drug, Dependency will be paid at 50% (after the deductible) of the covered expense up to a maximum of $25,000 during the lifetime of the insured. The Preferred

Provider Organization Plan may reduce coverage to 40% if an insured person does not obtain services from a medical provider that has contracted with the pool. Out-of-Pocket expenses for such treatment will not be used to satisfy the Maximum Out-of-Pocket Expense Amount described in section 9.

008.01I ~~The following~~ eExpenses will be paid ~~when an insured female incurs expense~~ for mammographic screening as ~~defined~~required by Neb.Rev.Stat. §44-785~~(3)~~.

~~008.01I(1) One baseline mammogram for the insured female who is between 35 years of age and 39 years of age.~~

~~008.01I(2) One mammogram every two years for the insured female who is between 40 years of age and 49 years of age~~.

~~008.01I(3) One mammogram. every year for the insured female who is 50 years of age or older.~~

008.01J Childhood immunizations for children from birth to six years of age including vaccinations for measles, mumps, rubella, poliomyelitis, diptheria, pertussis, tetanus, haemophilus influenzae type B.

008.01K Coverage for a newly born child of the insured, from the moment of birth, for a period of 31 days.

008.01L Coverage for up to six consecutive weeks of hospital outpatient rehabilitation services for cardiac or pulmonary rehabilitation.

008.01M Coverage for up to 60 inpatient days per calendar year for covered services for physical rehabilitation, as defined in the policy.

009. Maximum out-of-pocket expense . Once the insured has incurred $1,500~~2,000~~ in out-of-pocket expenses in a calendar year, over and above the deductible, benefits will be paid at 100% for the remainder of that calendar year, subject to the exceptions indicated elsewhere in this rule. The Preferred Provider Organization Plan may increase the maximum out-of-pocket expense to $3,000 for those services and supplies received from medical providers that have not contracted with the pool.

010. Maternity benefit rider.

010.01 An optional maternity benefit rider will be available to individuals enrolled in the pool upon payment of an additional premium.

010.02 Benefits will be paid as described in subsection 010.03 if the individual is:

010.02A Insured under the rider at least nine months prior to the birth, except as waived by Neb.Rev.Stat. §44-4228(5);

010.02B Confined for normal pregnancy or normal childbirth; and

010.02C Continuously insured under the rider and the policy during the entire period of the pregnancy.

010.03 Benefits will be paid for the expense incurred for covered services and supplies up to, but not to exceed a total maximum benefit of $3,000.

010.03A The provisions of section 008 of this rule do not apply to benefits payable under the rider.

010.04 Benefits due under the rider are not subject to the deductible described in section 004 of this rule.

010.05 No payments will be made for expenses:

010.05A Paid for under any other benefit provision of the policy;

010.05B For care of a newborn infant, except as provided by 008.01K.

011. Renewability of Policy Form

011.01 The board may nonrenew all policies issued on the same form number, subject to approval by the Director.

011.02 If the insured's policy is nonrenewed as stated in subsection 0 11. 0 1, the insured will be issued a replacement policy which will be the CHIP Policy Form then being issued to new enrollees. Any waiting period, deductible, out-of-pocket amount and maximums satisfied under the nonrenewed policy form will be carried forward and applied to the insured's replacement policy.

012. Severability. If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

013. Effective date. T'his regulation shall become operative on ~~October~~ January 1, ~~1998~~2001.